☐ **New Enrollment**
☐ **Change in Family Status**

4F

MONROE COUNTY
CAFETERIA/FLEXIBLE BENEFITS PROGRAM
2006 ENROLLMENT FORM

EMPLOYEE INFORMATION (Please Print)

Employee Name:		**Employee Social Security Number:**	
Address:	**City:**	**State:**	**Zipcode:**
Email Address:	**Home Telephone:**	**Work Telephone:**	

Birth Date Month / Day / Year	**Gender:**	**Marital Status:**	**Effective Date:** Month/Day/Year	**Human Resources Approval:**
	☐ **Male** ☐ **Female**	☐ **Single** ☐ **Married**	**PAYROLL USE ONLY** ____ / ____ / ____	

DEPENDENTS (Please Print)

	Name	Medical	Dependent Care	Birth Date	Social Security #
spouse		☐			
dependent		☐	☐		
dependent		☐	☐		
dependent		☐	☐		
dependent		☐	☐		

IMPORTANT:
By enrolling in the Cafeteria/Flexible Benefits Program I understand that:

- ◊ **I will be paid from the reallocation account(s) upon submission of properly prepared claim forms.**
- ◊ **I may not change my election during the Plan Year except for a change in family status.**
- ◊ **I may not transfer money between options (Health and Dependent Care).**
- ◊ **I will forfeit any balance remaining 90 days after year end.**
- ◊ **I may submit claims up to 30 days from the date of termination for services incurred prior to the termination date.**

☐ **I elect to have my out-of-pocket Monroe County Dental Expenses automatically paid through the Flexible Spending Account.**

☐ **I elect to have my Flexible Benefits check direct deposited into my checking or savings account. (Attach Direct Deposit Authorization Form)**

EMPLOYEE ELECTIONS

Benefit Election Options	Participation	Salary Reduction Amount		
Medical/Dental/Vision Account Maximum of **$3,000** per plan year.	**YES** ☐ **NO** ☐	$_____ **PLAN YEAR**	No. of pay periods during the Plan Year. **26**	DO NOT WRITE IN THIS BOX $_____ **per pay period**
Dependent Care Account Maximum of **$5,000** per plan year. ($2,500 if married filing separately) **YOU MUST COMPLETE AND SUBMIT FEDERAL FORM W-10 FOR EACH CHILD CARE PROVIDER**	**YES** ☐ **NO** ☐	$_____ **PLAN YEAR**	No. of pay periods during the Plan Year. **26**	$_____ **per pay period**

NOTE: Amounts allocated to Health Care and/or Dependent Care are pre-tax expenditures. New employees; if you enroll after the beginning of the Plan Year, pay period amounts will be prorated according to the length of time remaining in the plan year. If an annual amount is not evenly divisible by the number of pay periods, the pay period amount will be rounded downward.

Employee Signature: _____ **Date:** _____

Please return this enrollment by December 2, 2005 to: **Human Resources, Room 210**
County Office Building
39 West Main Street
Rochester, NY 14614